Correctional Facilities —Kleanthe Caruso, National Commission on Correctional Health Care

I have been associated with correctional facilities for 16 years and have been in health care for over 25 years. I'm a registered nurse and have been responsible for the state of Texas health care delivery system for the state Department of Corrections. I am also the Chairman of the Board of the National Commission on Correctional Health Care.

Correctional facilities are really a mirror of the community. The people that come to the facilities have behaviors that put them at risk for serious health problems. Every state has a variety of correctional facilities—local, county, state, and federal.

Of all the prisons in the United States, about 450 are accredited by the National Commission on Correctional Health Care. Some of the standards apply to perinatal HIV elimination.

1. **Continuity of care** from admission into prison to discharge into the community is an important standard.
2. **Special needs offenders** have been identified as those people who have infectious diseases and women who are pregnant. Special needs treatment plans are written for these persons. Because correctional facilities have limited resources, are in remote locations, and have limited providers, they have taken advantage of community services, departments of health, and indigent care hospitals to provide for special populations.

What is the number of women in prison?

As of December 31, 1998, there were over 1,300,000 prisoners in federal and state jurisdictions. The number of incarcerated women under the jurisdiction of state and federal authorities increased about 6.5% during 1998 (79,268 to over 84,000), outpacing the rise in the number of men. These numbers do not include those in juvenile facilities.

What is the prevalence of HIV in correctional facilities?

Inmates have a higher rate of infectious disease than that of the general population. At year-end 1996, the rate of confirmed AIDS in state and federal prisons was 6 times higher than that of the total U.S. population. About 54 in 10,000 inmates had AIDS compared with 9 in 10,000 in the general population. In local jails as of 1996, of 31,972 females, 2.4% were HIV-positive compared with 2.1% of males. In state prisons, the number of females was over 55,800, with HIV prevalence at 3.4% compared with males at 2.2%. In the federal system, the prevalence among males and females was about the same.

New York has about a third of all the HIV-positive inmates in the United States, followed by Florida, Texas, and California. HIV prevalence is higher in females than males, and in black and Hispanic inmates.

What is the medical care system in correctional facilities?

Despite the above data, few correctional systems have implemented comprehensive HIV

prevention programs. Most settings provide HIV antibody testing, but only seven states provide mandatory testing. Methods vary among states. Few have mandatory or routine pregnancy testing. Once a women is identified as pregnant, she is provided medical examinations, advice on activity and safety, and nutritional guidance and counseling.

Pregnant women released before delivery are handled by case management programs in prisons. Case managers may give the woman a booklet with the names of the closest providers, pharmacy numbers, local resources; they may set up hospital appointments for the women. Most offenders come from big cities, so resources could be concentrated in selected areas.

Is HIV care available in correctional facilities?

Most correctional facilities do provide treatment and medication for HIV-positive offenders. However, the programs and therapies vary among facilities, which depend on contract or community resources to keep them up to date. Most facilities are located in remote areas of the state, without much access to continuing education for their providers. More states have recently turned to contracting with outside providers or using telemedicine technologies to provide these services.

When an offender is on HIV treatment, the attitude of the health provider influences the behavior of the offender. Providers must understand the treatment climate when talking about compliance. Medications are generally not dispensed to inmates as they would be to someone in the community. Inmates may need to walk to a dispensary several times a day to obtain medication; this need underscores the importance of counseling and stressing the importance of adherence. Lack of adherence may contribute to resistant strains in these people who will eventually return to the community.

Is HIV care linked with community agencies?

Once a pregnant inmate is identified, she is referred to a community hospital, indigent care facility, or an individual health care provider. This is the first opportunity for community linkage with pregnant HIV-infected offenders. Because the female population is usually much smaller than the male population, these linkages are usually limited to one community site; this gives the community another opportunity to link with correctional facilities because they are not having to span the entire state.

Because many communities do not have a lot of sympathy for delivery of health care in correctional facilities, the federal government got involved and said it was a Constitutional right. Limited dollars go to prisons, jails, and detention facilities, and not all of it goes to health care.

What are the policies on compassionate release?

Policies for the early and compassionate release of inmates with terminal illnesses, including end-stage AIDS, are common, but few inmates are actually released.

What are the issues with relation to baby placement and baby care?

Most correctional facilities give pregnant women options on baby placement; e.g., whether the

baby will go to the family, significant other, foster care, adoption. The decision is communicated to the hospital where the woman delivers. HIV-infected pregnant women need more consideration as to where the baby will go because of the needs of the infant for medication, laboratory work, and whether the infant's caretakers are willing to do this and whether the resources are available in the community.

For the management of HIV-infected pregnant woman, the key points are

- Identification and referral to appropriate (infectious disease and obstretrics) service
- Evaluation of the woman (Previously on medication? Compliant? Willing to start treatment? Baby placement? Continuity of care?)

The burden is to link up with these women before they are released into the community and ensure a smooth transition once they are released from the correctional institution.

Because incarcerated women are not eligible for Medicaid, there is a lag time between release and eligibility. Most HIV-infected offenders are given a short-term supply of medication before leaving the facility. Every state handles case management differently in terms of connecting with communities. Texas has a federally funded program with an 800 number that HIV-infected women can call to get the name of a participating pharmacy for a free supply of medication. Last year, only 40 out of 100 eligible persons made the effort to place the call, emphasizing the need for community follow-up.

Contact Information

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